Dr. Michael Kennedy
Chanhassen Wellness Chiropractic
470 West 78th Street, Suite 220
Chanhassen, MN. 55317 952-607-6416

Patient Information

Date : ____/_____/______

Last name ______________________________ First ______________________________ MI __________

Address ______________________________ City ____________________ State __________ Zip __________

Cell/Home Phone: c: _________________________ h: _____________________ Gender M or F

Date of Birth _______________________ Age __________ Email

Marital Status _____________ # Children _____

Spouse's Name _______________________________ Parent's Names (if you are under 18) ________________________

Emergency Contact Name ____________________________ Relation _____________ Phone#

Employer ____ Work Phone ____

Occupation ____

How did you hear about us? ____

Do you have Health Insurance or Medicare? □Yes □No Company ____

Policy Holder: _________________________________ DOB: ____

Do you have secondary/supplemental health insurance? □Yes □No Company __________________________________

Do you have a Flex Plan, Health Savings Account, or Cafeteria Health Plan? □Yes □No Describe ___________________

If you have insurance, please present your card(s) to the office manager for processing.

Have you seen a Chiropractor in the Past? □Yes □No If Yes, when was your most recent visit? _____________

Why did you see the Chiropractor? ____

Doctor's Name/clinic: ____

What frequency was prescribed for your ongoing maintenance care? ____________________________________

Why are you changing chiropractors? ____

When was your most recent set of spinal x-rays? ____

Check any of the following that you are currently using/wearing: □ Heel lift □Arch Supports □Back brace

Who is your Primary Medical Physician? ___________________________ Clinic: _____________________

Phone: ____

When was your last set of medical blood or urine tests? ____

Symptoms:

Describe your current injury or your current problem/symptoms:______________________________________

What do you think is the likely cause of your current problem?______________________________________

How has your problem, injury or affliction changed your life?______________________________________

Please mark your symptoms on the diagram:

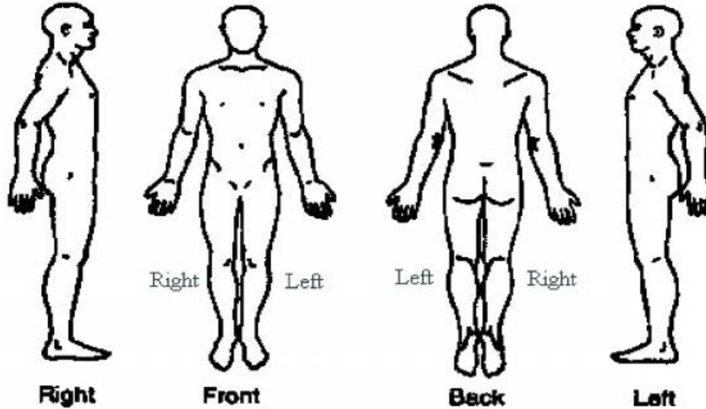
Aching - XXX

Burning - ###

Numbness - ///

Pins/Needles - 000

Stabbing - ●●●



Doctor Use Only:

Rate your pain right now (mark as "O"); average pain level (mark as "X")

Progression (circle): Improving Not-Improving Worsening **What makes it worse?**_____________________

Describe: Sharp Shooting Achy Burning Numb Tingling **What makes it better?**_______________

How severe are the symptoms on a scale of 1-10? (circle) NONE - 1 2 3 4 5 6 7 8 9 10-WORST

In general, how would you rate your current overall health? Excellent Very good Good Fair Poor

Has it affected your ability to work or do housework? □Yes □No How many days off from work/housework?_____________

What are your favorite hobbies or activities?____**Currently Affected?** □Yes □No

What activities do are you looking forward to doing in retirement?____

How do you want us to handle your problem? (check one)

□ Temporary Relief (Help the symptom but do not fix the cause of the problem)

□ Maximum Correction (Correct the cause of the problem for maximum stability and improve overall health)

Why did you come into our clinic and what are your expectations of us:____

____

Do you have any food or other know allergies? □Yes □No If yes, please list: ____

HEALTH HISTORY:

Last known: Height__________ Weight____________ Blood Pressure __________/____________(don't know)
What is your exercise routine? ____
How do you de-stress?____
Are you pregnant? □Yes □No
Have you experienced any unexplained weight gain **or** weight loss **in the last 6 months** □Yes □No
Describe your diet ____
Please read the list and check the box next to each condition that applies/applied to you:

Musculoskeletal - General
Now Past
□ □ Degenerative arthritis
□ □ Rheumatoid arthritis or Gout
□ □ Compression fracture
□ □ Osteomyelitis
□ □ Osteoporosis

Musculoskeletal Spine
□ □ Poor Posture
□ □ Disc injury
□ □ Neck problem
□ □ Mid-back problem
□ □ Low back problem
□ □ Scoliosis
□ □ Ankylosing spondylitis
□ □ Difficulty swallowing because of neck pain
□ □ Pain or electric shocks in arms or legs on moving neck

Musculoskeletal Extremity
□ □ Hip or sacroiliac problem L R
□ □ Leg, Knee, ankle or foot L R problem
□ □ Shoulder problem L R
□ □ Arm,elbow,hand problem L R
□ □ Rib or chest pain

Nervous System
□ □ Headaches or migraines
□ □ Tingling or numbness of arms, legs, hands or feet
□ □ Pinched nerve or sciatica
□ □ Poor balance
□ □ Depression or Anxiety
□ □ Difficulty dealing with stress
□ □ Dizziness or vertigo
□ □ Learning disorder or hyperactivity (ADD/ADHD)
□ □ Seizures/Epilepsy
□ □ Recent progressive muscle weakness or shaking
□ □ Numbness of inner thighs/groin

EENT
□ □ Jaw, TMJ or mouth problem
□ □ Chronic sinus problems
□ □ Face pain
□ □ Visual problems

GI/GU/Endocrine
Now Past
□ □ Abdominal pain
□ □ Constipation/Diarrhea
□ □ Heartburn/Acid Reflux/Ulcers
□ □ Uncontrolled Bladder or Bowel
□ □ Inflammatory bowel disease
□ □ Liver or gallbladder problems
□ □ Menstrual problems or PMS
□ □ Menopause symptoms
□ □ Difficulty getting/staying pregnant/other

Cardio-Pulmonary
□ □ Pacemaker or implanted device
□ □ Breathing trouble or Asthma
□ □ High blood pressure
□ □ History of stroke or aneurysm

Medication-Related Issues
□ □ Medication dependence
□ □ Drug or Vaccination reaction
□ □ Current drug side-effects
□ □ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
□ □ 3 or more months of steroid medications or intravenous drugs (past or present)

Injuries and General Constitution
□ □ Car crash/whiplash injuries
□ □ Work injuries
□ □ Ergonomic stress at work
□ □ Sports injuries
□ □ Smoking habit: How much/day?___________
□ □ Drug or alcohol dependence or recovering
□ □ Psoriasis or psoriatic arthritis
□ □ Unexplained weight loss
□ □ Sleeping trouble
□ □ Get sick a lot/poor immune function
□ □ Fibromyalgia / Chronic fatigue
□ □ Ear problems/infections
□ □ Tuberculosis, Hepatitis or HIV
□ □ Cancer or Tumor

Allergies:______________________
____
____
____

Now Past
□ □ Recent fever over 102°F
□ □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
□ □ Constant pain that doesn't improve by changing positions or by lying down
□ □ **OTHER HEALTH PROBLEM NOT LISTED**:
____
____

FAMILY HISTORY
(circle any that apply)
Back problems / Back/neck surgery / Heart problems / Diabetes / Rheumatoid arthritis / high blood pressure / Cancer /
Other:________________________
____

LIST SURGERIES/PROCSEDURES:
____
____
____

LIST ALL MEDICATIONS:
____
____
____
____
____

LIST SUPPLEMENTS/VITAMINS:
____
____
____

Informed Consent

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known, I will tell the doctor when possible so that it can be added to my record. Having carefully read the "Informed Consent" (below), I hereby give my informed consent to have chiropractic treatment administered.

I hereby authorize Dr. Michael Kennedy to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiation care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities associated with Chiropractic care:
Soreness- Chiropractic Adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy.
Soft-Tissue Injury – Occasionally chiropractic Treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.
Rib Injury – Manual Adjusting to the thoracic spine, in rare cases, may cause rib injury or fracture. Treatment is performed carefully to minimize such risk.
Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.
Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

____
Patient Signature

____
Doctor Signature

____
Interpreter Signature

____
Parent or Guardian Signature

Any missed appointments without cancelation within 12 hours charged $25

If you have insurance, please present your card(s) to the front desk for processing.

NOTICE OF PRIVACY PRACTICES

This Notice Applies to Chanhassen Wellness Chiropractic

[As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)]

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITY UNDER THE FEDERAL PRIVACY STANDARD
In addition to providing you with your rights, as detailed below, the federal privacy standard requires Chanhassen Wellness Chiropractic to:

- Maintain the privacy of your health information, including implanting reasonable and appropriate physical, administrative and technical safeguards to protect the information.
- Provide you with the notice as to our legal duties and privacy practices with respect to the individually identifiable health information we collect and maintain about you.
- Abide by the terms of this Notice.
- Mitigate (lessen the harm of) any breach of privacy or confidentially.

All Chanhassen Wellness Chiropractic employees, contracted individuals who are involved in providing your care are expected to follow the privacy practices as stated in the Notice.

USE AND DISCLOUSRE OF HEALTH INFORMATION
Chanhassen Wellness Chiropractic will not use or disclose your health information without your authorization, except as described in this Notice or otherwise required by law. We reserve the right to change our practices and to make the new provisions effective for all individual identifiable health information we maintain. Should we change our information practices, you may request a copy of the Notice by calling our office (952) 607-6416. The following are examples of how Chanhassen Wellness Chiropractic will use and disclose your health information for treatment, payment and healthcare operations. These examples are not meant to be inclusive, but describe types of uses and disclosures.

To Provide Treatment
We will use your health information within our office to provide you with health care treatment, including administrative and clinical office procedures. In addition, we may share your health information with health care personnel proving your treatment.

To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in your office. We may do this with insurance forms filed for you via mail or email.

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials health information necessary to complete an investigation related to public health or national security

For Law Enforcement
As permitted by law, we may disclose your health information to law enforcement officials for certain purposes including under limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your treatment or payment. We will be sure to ask your permission first.

PATIENT RIGHTS

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. We will make every effort to honor reasonable restrictions.

Inspect and Copy Your Health Information

You have the right to read review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know.

Amend Your Health Information

You have the right to ask us to update or modify your records, if you believe your health information records are incorrect or incomplete. To standardize this process, please provide us with your request I writing and describe your reason for the change. Your request may be denied if the record in question was not created by our office, is not part of our records, or if the records are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations. Tell us in writing the time period you are interested in. Thank you for limiting your request to no more than six years at a time.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this notice of privacy practice directly from our office. We are required by law to maintain the privacy of your health information and to provide you this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please express any concerns to us in writing within 180 days of when you knew or should have known when that/the act had occurred. Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.

You have the right to refuse to sign this authorization. If you refuse to sign, Chanhassen Wellness Chiropratic will provide treatment. This Notice is effective October 10, 2009.

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Chanhassen Wellness Chiropractic for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledged, understand the content of the Notice of Privacy Practices and have had all my questions answered to my satisfaction.

Printed Patient Name____Date_________________

Signature ____

Printed Name of Parent/Guardian ____Date_________________

Signature of Parent/Guardian ____

Signature of Privacy Officer____Date_________________